Covid-19 SERO Survey round two

Address of the participant

Region name

Region code

Zone _Name

Zone _CODE

Woreda _ name

Woreda _ Code

Town _Name

Town _CODE

SUBCITY_CODE

Cluster_ID

EA code

HH selection order

Demographic and identifying information

Date of Interview

dd/mm/yy

yyyy-mm-dd

Study ID No

Interviewer Name

Participant ID number (write region code, Zone/Sub city code, Woreda code ,Cluster Code, HH selection order)

generated by writing region code, Zone/Sub city code, Woreda code, Cluster Code, and HH selection order respectively

Sex

- ◯ Male
- ◯ Female

Date of Birth

If day or month unknown, indicate year

yyyy-mm-dd

Age

Household ID number

GPS coordinates

lat/long in decimal degrees

latitude (x.y °)

longitude (x.y °)

altitude (m)

accuracy (m)

Telephone (mobile) number

Location

District/State

Community

Address/house number

Urban or Rural community

- ◯ Urban
- ◯ Rural

Total number of household residents

Enter number

Occupation

- ◯ Healthcare/health facility worker (e.g. nurse, doctor, hospital staff)
- ◯ Public-facing sales and services (shop, driver, tourism, education, banking)
- ◯ Professional/technical/ managerial
- ◯ Clerical
- ◯ Skilled manual (plumber, mechanic, etc)
- ◯ Unskilled manual (day laborer, guard, etc)
- ◯ Agriculture
- ◯ Housewife
- ◯ Student (primary or secondary)
- ◯ Unemployed
- ◯ Other, specify
- ◯ Don't know
- ◯ Refused

Healthcare/health facility worker, have you had contact with patients you know or suspect had COVID-19 at the time?

- ◯ Yes
- ◯ No
- ◯ Don't know

COVID Vaccine History

Have you been vaccinated against COVID- 19?

- ◯ Yes
- ◯ No
- ◯ Don't know

If yes, how many doses of vaccine have you received?

- 1 dose
- 2 doses
- Booster dose (3 dose)

Date of dose 1

yyyy-mm-dd

Date of dose 2

yyyy-mm-dd

Date of dose 3

yyyy-mm-dd

do you know the name of Vaccine received?

- Yes
- No

If you Received Vaccine which of the following vaccine type, you were received?

Sinopharm

- Yes
- No

AstraZeneca

- Yes
- No

Johnson & Johnson/Janssen

- Yes
- No

Pfizer-BioNTech

- Yes
- No

Was written documentation of vaccine information provided?

For interviewer

- Yes
- No, verbal only

Symptom History

Have you previously tested positive for COVID-19

If no, move to question 2

- Yes
- No

If yes, by what test?

- PCR
- Rapid antigen test
- Rapid antibody test
- Don't recall/know

If yes, what is the date you were diagnosed

Day/Month/Year

yyyy-mm-dd

If yes, did you have any of the following symptoms in association with your COVID- 19 diagnosis?

Fever ≥38°C

- Yes
- No
- Don't recall

Chills

- Yes
- No
- Don't recall

Fatigue

- Yes
- No
- Don't recall

Muscle ache (myalgia)

- Yes
- No
- Don't recall

Sore throat

- Yes
- No
- Don't recall

Cough

- Yes
- No
- Don't recall

Runny nose

- Yes
- No
- Don't recall

Shortness of breath

- Yes
- No
- Don't recall

Wheezing

- Yes
- No
- Don't recall

Chest pain

- Yes
- No
- Don't recall

Headache

- Yes
- No
- Don't recall

Loss of smell

- Yes
- No
- Don't recall

Loss of taste

- Yes
- No
- Don't recall

Diarrhoea

- Yes
- No
- Don't recall

Other symptoms

_____

Date symptoms started

Day/Month/Year

yyyy-mm-dd

Duration of symptoms (in days)

Since March 2020, how many times have you been sick/ ill?

- ◯ One times (1st illness)
- ◯ Two times(2nd Illness)
- ◯ Three times(3rd Illness)
- ◯ More than three times illness
- ◯ No illness

Illness 1

Date when symptoms started for 1st illness

Day/Month/Year

yyyy-mm-dd

Duration of symptoms for 1st illness

days, weeks, month

Which of the following symptoms did you experience?

Fever ≥38°C

- ◯ Yes
- ◯ No
- ◯ Don't recall

Chills

- ◯ Yes
- ◯ No
- ◯ Don't recall

Fatigue

- ◯ Yes
- ◯ No
- ◯ Don't recall

Muscle ache (myalgia)

- Yes
- No
- Don't recall

Sore throat

- Yes
- No
- Don't recall

Cough

- Yes
- No
- Don't recall

Runny nose

- Yes
- No
- Don't recall

Shortness of breath

- Yes
- No
- Don't recall

Wheezing

- Yes
- No
- Don't recall

Chest pain

- Yes
- No
- Don't recall

Headache

- Yes
- No
- Don't recall

Loss of smel

- Yes
- No
- Don't recall

Loss of taste

- Yes
- No
- Don't recall

Diarrhea

- Yes
- No
- Don't recall

Illness 2

Date when symptoms started for 2nd illness

Day/Month/Year

yyyy-mm-dd

Duration of symptoms for 2nd illness

Which of the following symptoms did you experience?

Fever ≥38°C

- Yes
- No
- Don't recall

Chills

- Yes
- No
- Don't recall

Fatigue

- Yes
- No
- Don't recall

Muscle ache (myalgia)

- Yes
- No
- Don't recall

Sore throat

- Yes
- No
- Don't recall

Cough

- Yes
- No
- Don't recall

Runny nose

- Yes
- No
- Don't recall

Shortness of breath

- Yes
- No
- Don't recall

Wheezing

- Yes
- No
- Don't recall

Chest pain

- Yes
- No
- Don't recall

Headache

- Yes
- NO
- Don't recall

Loss of taste

- Yes
- No
- Don't recall

Diarrhea

- Yes
- No
- Don't recall

Illness 3

Date when symptoms started for 3rd illness

Day/Month/Year

yyyy-mm-dd

Duration of symptoms for 3rd illness

Which of the following symptoms did you experience?

Fever ≥38°C

- Yes
- No
- Don't recall

Chills

- Yes
- No
- Don't recall

Fatigue

- Yes
- No
- Don't recall

Cough

- Yes
- No
- Don't recall

Runny nose

- Yes
- No
- Don't recall

Shortness of breath

- Yes
- No
- Don't recall

Wheezing

- Yes
- No
- Don't recall

Chest pain

- Yes
- No
- Don't recall

Headache

- Yes
- No
- Don't recall

Loss of smell

- Yes
- No
- Don't recall

Loss of taste

- Yes
- No
- Don't recall

Diarrhea

- Yes
- No
- Don't recall

Symptom complications (If any symptoms reported)

_____

Did any of these symptoms require you to seek medical attention?

- Yes
- No
- Unknown

Did any of these symptoms require you to miss work or school?

- Yes
- No
- Unknown

Did any of these symptoms require you to be hospitalized?

- ◯ Yes
- ◯ No
- ◯ Unknown

Did you receive any of the following treatments while you were hospitalized

Steroids (e.g. dexamethasone, prednisone, prednisolone)

- ◯ Yes
- ◯ No
- ◯ Don't recall/know

Antibody treatment (e.g. convalescent plasma, monoclonal antibodies

- ◯ Yes
- ◯ No
- ◯ Don't recall/know

Oxygen therapy

- ◯ Yes
- ◯ No
- ◯ Don't recall/know

Remdesivir

- ◯ Yes
- ◯ No
- ◯ Don't recall/know

Intubation and mechanical ventilation?

- ◯ Yes
- ◯ No
- ◯ Don't recall/know

What was the date of your admission to hospital

yyyy-mm-dd

What was the date of your discharge from hospital

yyyy-mm-dd

Pre-existing medical conditions

Have you ever been diagnosed with any of the following?

Obesity

- ◯ Yes
- ◯ No

Diabetes

- ◯ Yes
- ◯ No

Chronic lung disease (other than TB)

- ◯ Yes
- ◯ No

High blood pressure

- ◯ Yes
- ◯ No

Serious heart condition such as heart failure, previous heart attack, or similar problem.

- ◯ Yes
- ◯ No

Neurological condition such as seizures, paralysis, or delayed development

- ◯ Yes
- ◯ No

Chronic kidney disease

- ◯ Yes
- ◯ No

HIV infection or AIDS

- ◯ Yes
- ◯ No

If yes, on antiretroviral therapy?

- ◯ Yes
- ◯ No

TB

- ◯ Yes
- ◯ No

Sickle Cell anemia

- ◯ Yes
- ◯ No

Cancer

- ◯ Yes
- ◯ No

Other

if there is any other than the above mentioned

_____

Are you pregnant? (for women between the ages of 15 – 49 years)

- ◯ Yes
- ◯ No

If yes, what trimeste

_____

Do you smoke tobacco products?

- ◯ Daily
- ◯ Less than daily
- ◯ Former smoker
- ◯ Never smoked

Do you practice social distancing

- ◯ Never
- ◯ Sometimes
- ◯ Always

Do you use face mask

- ◯ Never
- ◯ Sometimes
- ◯ Always

Do you wash your hand

- ◯ Never
- ◯ Sometimes
- ◯ Always

SARS-CoV-2 Anti body Testing

Rapid Diagnostic Test type

- ◯ IgM antibody
- ◯ IgG antibody
- ◯ Both IgM and IgG antibody
- ◯ Antigen
- ◯ Other

IgM test result

- ◯ Positive
- ◯ Negative

IgG test result

- ◯ Positive
- ◯ Negative

Both IgM and IgG antibody

answered only if two line seen on both IgG and IgM

- ◯ Positive
- ◯ Negative

Assessment of Risk of exposure/ transmission on Covid-19

Did you believe that you have had COVID- 19

- ◯ Yes
- ◯ No

Did you practiced or used PPE (face covering, gloves)

- ◯ Yes
- ◯ No

Did you practiced social distancing

- ◯ Yes
- ◯ No

number of days and reasons left home in past 7 days

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did you traveled from home in past 7 days

- ◯ Yes
- ◯ No

Do you believe that staying home is effective at slowing the spread of COVID-19

- ◯ Yes
- ◯ No

did you had a close contact with someone with COVID-19

- ◯ Yes
- ◯ No

previously tested for COVID- 19

- ◯ Yes
- ◯ No

If Yes, what is the types of test performed

- PCR
- Rapid antigen test
- Rapid antibody test
- Don't recall/know

If Yes, what is the result of Covid-19 test

- Posetive
- Negative
- Don't recall/know

Symptoms of COVID- 19

Did you experienced Covid-19 symptoms since start of pandemic

- Yes
- No
- Don't recall/know

experienced symptoms within last 7 day

- Yes
- No

do yo have Fever now?

- Yes
- No

Did You received any medical attention for COVID-19

- Yes
- No

Known medical conditions or Co-Morbidities

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lung disease (e.g. asthma, emphysema, COPD)estion

- Yes
- No
- Unknown

diabetes

- Yes
- No
- Unknown

high blood pressure(Hypertension)

- ◯ Yes
- ◯ No
- ◯ Unknown

Obesity?

- ◯ Yes
- ◯ No
- ◯ Unknown

Chronic kidney disease?

- ◯ Yes
- ◯ No
- ◯ Unknown

Chronic heart (cardiac) disease?

- ◯ Yes
- ◯ No
- ◯ Unknown

Malignant neoplasm(cancer)?

- ◯ Yes
- ◯ No
- ◯ Unknown

liver disease?

- ◯ Yes
- ◯ No
- ◯ Unknown